DEPART	MENT OF HEALTH	AND HUMAN SERVICES	هسه ا ر	Ct all 115): 08/01/2012 AAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<u> 45</u>	- 1/16/12		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION '	(X3) DATE S COMPL	
		445076	B. WING		07/	30/2012
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NHC HEA	ALTHCARE, MCMINN	VILLE	l l	928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 022 SS=D	NFPA 101 LIFE \$A	FETY CODE STANDARD	K 022	•		
K 038 II SS=D	visible signs in all careach exit is not rea occupants. 7.10.1 This STANDARD is Based on observation facility failed to mark signs in all cases whexit is not readily appropriate facility failed to mark exit is not readily appropriate finding included. Observation on 7/30, exit access doors in marked with "Exit" signal the facility admir conference on 7/30/1NFPA 101 LIFE SAFExit access is arranged.	not met as evidenced by: on, it was determined the exits with readily visible ere the exit or way to reach parent to the occupants. /12 at 12:16 PM revealed the the dining room were not gns. fied by the maintenance staff histrator during the exit	K 038	1. Corrected Actions According Maintenance Super Maintenance Assistant in new Exit Lights Indicating access doors in the dining 8/08/12. 2. How We Have Identified Potential Areas Affected Same Practice and Corrective Action Maintenance Supervisor Maintenance Assistant et all exit doors for proper No further exit doors we without required signage. 3. What Done to Ensure The Practice Does Not Recursion Maintenance Supervisor Administrator will ensure signs are in place with any or building modifications. 4. The Corrective Action Monitored To Ensure Practice Will Not Recursion Maintenance Supervisor with all exit signs are in place with any or building modifications. 4. The Corrective Action Monitored To Ensure Practice Will Not Recursion Maintenance Supervisor with all exit signs are in place working monthly times 4 to ensure substantial complianchieved. Results will be reto the QA Core (Administrator, Director, Information and Assistant Information and Assistant Information and Assistant Information and Assistant Information.	visor and installed 3 g the exit g room on ed Other d by the What Taken. or and examined signage. re found "hat the ir. The r and e "Exit" remodel Will Be e the r. The ill check ice and months liance is eported inmittee r of Health	
				Completion	n Date:	8/08/12
ABORATORY (DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012 FORM APPROVED OMB NO. 0938-0391

CENTER	KS FOR MEDICARE	& MEDICAID SERVICES					OND NO.	. 0830-0381
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUC G 01 - MAII	TION N BUILDING 01	(X3) DATE S' COMPLE	URVEY EYED
445076		B. WII	NG_			07/30/2012		
NAME OF P	ROVIDER OR SUPPLIER			STF	EET ADDRESS,	CITY, STATE, ZIP CODE		į
NUC UE	ATTHORDE BACKHING	n#11 E		9:	28 OLD SMITH	VILLE RD		-
MUCKE	ALTHCARE, MCMINN	VILLE		N	IC MINNVILL	E, TN 37110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH (VIDER'S PLAN OF CORRECTIVE ACTION SE EFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
					K038			
K 038	Continued From pa	- :	K	038	The remov	ved the "Exit" sign	upervisor	
		is not met as evidenced by:				rence room from the		
1		tions, it was determined the				on 7/31/12. A		
	facility failed to provide exits readily accessible at all times.					alk will be installe		
						the 400 hall	exit and	!
	The findings includ	ed:				yard on 9/16/12.		
						We Have Identifi		!
	Observation on 7/30/12 at 10:50 AM revealed the facility had exit access from the therapy room through the conference room. Path through the confrence room was obstructed by table and chairs.					itial Areas Affecte	•	
					Same	Practice and ctive Action Take		
						enance Supervis		
						enance Assistant ch		
	· Origina.	1				ng "Exit" were		!
	2. Observation on 7/30/12 at 12:07 PM revealed					sible and those ou	•	
		rom the 400 hall did not have				all-weather hard sur		;
	all-weather hard su	rface to the public way.			public	ways.		
	·					Done to Ensure		1
		7/30/12 at 12:08 PM revealed				ice Does Not Recur		
		from the courtyard did not have in Inface to the public way.				in-serviced on 8/	•	
	all-weather hard su	riace to the public way.				e all exits were	readily	
	These findings wer	e acknowledged by the				sible at all times. Corrective Action	Will Do	
		and the facility administrator			4. The Monit			
	during the exit conf			!	Pract		Recur.	į l
K 062	NFPA 101 LIFE SA	FETY CODE STANDARD	Κŧ	062		enance Supervis		1
SS=D		!				enance Assistant to		}
	Required automatic sprinkler systems are		:	exits :	are accessible mont	hly tim e s	!	
	continuously maintained in reliable operating					inths to ensure si		<u> </u>
,	condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA					will be	ļ	
,	periodically. 19.7 25, 9.7.5	.0, 4.0.12, N1 I'M 10, NEI'M		i		ted to the QA C		ļ
,	20, 01110	:				inistrator, Direc		.
:		:				ng, Medical Directo		
		s not met as evidenced by:		;	intorn of Nut	nation and Assistant	Director	1
					or war	arug).		
	Based on observation, it was determined the					Complet	ion Date:	9/16/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARI	E & MEDICAID SERVICES	,				1	0900-0001
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			TRUCTION • MAIN BUILDING 01	(X3) DATE SU COMPLE	RVEY TED
	445076		B. Wil	√G			07/30/2012	
NAME OF P	ROVIDER OR SUPPLIER		-			RESS, CITY, STATE, ZIP CODE		
NHC HEA	ALTHCARE, MCMINI	WILLE				MITHVILLE RD VILLE, TN 37110		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)				OULD BE ;	(X5) COMPLETION DATE
K 076 SS=D	Continued From particle facility failed to mare reliable operating of the finding included Observation on 7/3 shower curtains in and 100 halls obstanding was a maintenance staff during the exit con NFPA 101 LIFE S. Medical gas storage protected in according to the exit con Standards for Head (a) Oxygen storage 3,000 cu.ft. are en separation. (b) Locations for separation. (b) Locations for separation. This STANDARD Based on observations	age 2 intain the sprinkler system in condition. 30/12 at 11:21 AM revealed the shower rooms in the 200 ructing the sprinklers. cknowledged by the and the facility administrator ference on 7/30/12. AFETY CODE STANDARD ge and administration areas are dance with NFPA 99, lth Care Facilities. e locations of greater than closed by a one-hour upply systems of greater than inted to the outside. NFPA 99		076	2.	Corrected Actions Acco The Maintenance replaced shower curtai 200 and 100 hall show with curtains that have mesh to allow adequate coverage of all areas rooms on 7/31/12. How We Have Identif Potential Areas Affects Same Practice an Corrective Action Tal Maintenance Supervis Maintenance Assistant of areas of center to a sprinkler heads were un on 7/31/12. What Done to Ensure Practice Does Not Recure in-serviced on 8/ keeping sprinkler unobstructed. The Corrective Action Monitored To Ensure Practice Will Not Maintenance Supervis Maintenance Supervis Maintenance Assistant all areas in the center sprinkler heads are un weekly times four week monthly times three resure substantial con Results will be reported.	Supervisor ns in the ver rooms an 18-inch e sprinkler of shower ied Other ed by the d What cen. The sor and checked all assure all obstructed That the ar, All staff 30/12 on heads I Will Be ure the Recur. sor and will check to assure obstructed s and then months to ompliance. to the QA	
	with NFPA 99. The findings include	- -				Committee (Adn Director of Nursing, Director, Health Inform Assistant Director of Nur	nation and	
	1. Observation on 7/30/12 at 10:47 AM revealed			1			tion Date:	7/31/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		44 507 6	B. WING _		07/34	0/2812			
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, MCMINNVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
K 130 SS=D	2. Observation on 7 the oxygen cylinder in the therapy room empty. These findings were maintenance staff a during the exit confe NFPA 101 MISCEL OTHER LSC DEFICE OTHER LSC DEFICE National Fire Protes Safety Code: 8.2.3.2.4.2 Pipes, owires, air ducts, pnesimilar building servitorough fire barriers (1) The space between the fire barrier shall conditions: a. It shall be filled woof maintaining the fibarrier. b. It shall be protect is designed for the second of t	xygen cylinders in the oxygen of therapy room. 730/12 at 10:49 AM revealed in the oxygen storage room were not identified as full or eacknowledged by the end the facility administrator erence on 7/30/12. LANEOUS CIENCY NOT ON 2786 Sometiment as evidenced by: ction Association 101 Life conduits, bus ducts, cables, sumatic tubes and ducts, and ice equipment that pass shall be protected as follows: een the penetrating item and meet one of the following with a material that is capable are resistance of the fire ed by an approved device that expecific purpose. It is shall be barrier, and the space and the sleeve shall meet one of the sleeve shall meet one.	K 076	1. Corrected Actions According Maintenance remunsecured oxygen cylinder Therapy Storage room on The Station One charge nurse and marked the cylinders of 7/30/12. 2. How We Have Identifit Potential Areas Affected Same Practice and What Action Taken. Missupervisor, Maintenance Ass Respiratory Therapist of rooms in building for cylinders and for proper it cylinders. No findings, oxygen cylinder rack was in the Therapy Storage Area for cylinders. 3. What Done to Ensure Practice Does Not Recur. Were in-serviced on prope and labeling of oxygen cylinders of oxygen cylinders. 4. The Corrective Action Monitored To Ensure the	oved the s from the range and celing and s weekly ubstantial reported mistrator, Director, Assistant	7/30/12			

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING. 445076 07/30/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITHVILLE RD NHC HEALTHCARE, MCMINNVILLE MC MINNVILLE, TN 37110 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K130 K 130 K 130 Continued From page 4 Corrected Actions Accomplished. a. It shall be filled with a material that is capable The Maintenance Supervisor and of maintaining the fire resistance of the fire Maintenance Assistant sealed barrier. penetrations around the conduit through the fire wall adjacent to the b. It shall be protected by an approved device that Therapy Gym, around the conduit in is designed for the specific purpose. the fire wall by room 211, around the (3) *Insulation and coverings for pipes and ducts pipe through the fire wall by room 316, shall not pass through the fire barrier unless one around the communication conduit of the following conditions is met: and above the other pipe in the fire a. The material shall be capable of maintaining wall by shower room in the 400 hall the fire resistance of the fire barrier. and around the conduit in the fire wall b. The material shall be protected by an approved; by room 118 with Flame Stopper, device that is designed for the specific purpose. Smoke, Fire & Draft Stop on 8/3/12. (4) Where designs take transmission of vibration 2. How We Have Identified Other into consideration, any vibration isolation shall Potential Areas Affected by the Same Practice and What Corrective meet one of the following conditions: The Maintenance Action Taken. a. It shall be made on either side of the fire Supervisor and Maintenance Assistant checked all fire walls for any additional b. It shall be made by an approved device that is penetration on 7/30/12. No findings. designed for the specific purpose. What Done to Ensure That the Practice Does Not Recur. Supervisor Maintenance and Based on observations, it was determined the Maintenance Assistant will regularly facility failed to comply with the Life Safety Code. check fire walls for penetrations through regular preventative The findings included: maintenance checks. The Corrective Action Will Be Observation on 7/30/12 at 10:54 AM revealed Monitored To Ensure the Practice penetrations in the fire barriers in the following Will Not Recur. Maintenance Supervisor and Maintenance Assistant locations: will check fire-walls monthly for three months and then quarterly for nine a. Conduit through fire wall adjacent to therapy months to ensure substantial room. compliance. Results will be reported b. Above conduit in fire wall by room 211 to the QA Committee (Administrator, Above pipe through fire wall by room 316 Director of Nursing, Medical Director, Around communication conduit and above Health Information and Assistant other pipe in fire wall by shower room in 400 hall Director of Nursing). e. Around conduit in fire wall by room 118 Completion Date: 8/03/12

Facility ID: TN8901

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JETIPL	E CON	ISTRUCTION	(X3) DATE SI	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 445076		IDENTIFICATION NUMBER:	-	A. BUILDING 01 - MAIN BUILDING 01				TED
		B. WIN	<u>е —</u>			07/30/2012		
	ROVIDER OR SUPPLIER	VILLE		928	OLD	ORESS, CITY, STATE, ZIP CODE SMITHVILLE RD NVILLE, TN 37110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	k .		PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SH IOSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 130		e acknowledged by the and the facility administrator	K 1	:	147			
K 147 \$S=D	NFPA 101 LIFE SA Electrical wiring and with NFPA 70, Nat This STANDARD i	FETY CODE STANDARD d equipment is in accordance ional Electrical Code. 9.1.2 s not met as evidenced by: ions, it was determined the	K 1		1.	The Maintenance Assista the faceplate on the electri room 200, removed the from the Director of Nu removed the multi-plug ar room 412 and replaced junction box cover on 7/31 How We Have Identi	nt replaced cal outlet in power strip rse's office, dapter from the missing /12. fled Other	
	facility failed to mai equipment. The findings include 1. Observation on the faceplate on an had broken off.	ntain the electrical wiring and ed: 7/30/12 at 11:22 AM revealed electrical outlet in room 200			3.	Potential Areas Affects Same Practice and What Action Taken. The Massistant checked all electric checked all offices for proposer strips, checked all improper use of multi-pluand checked all junction 7/31/12. No additional fin What Done to Ensure Practice Does Not Recu	Corrective Maintenance rical outlets, oper use of rooms for ag adapters, boxes on dings. That the	
	back to back power Director of Nursing office. 3. Observation on	7/30/12 at 11:52 AM revealed strips running between the office and the MDS Nurse 7/30/12 at 12:06 PM revealed		-	4.	******	per use of ug adapters Will Be he Practice Maintenance	
	a junction box was mechanical room both	7/30/12 at 12:10 PM revealed missing a cover in the y the front offices. a acknowledged by the and the facility administrator		**************************************	Supervisor and Maintenance Assistant will check for electrical outlet faceplates, proper use of power-strips, use of multi-plug adapters and junction box covers monthly for 4 months to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing). Completion Date:			

Event ID: QPRE21